| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This report is the result of an unannounced Quality Indicator Survey conducted at Canterbury House on 08/21/13, 08/22/13, 08/23/13, 08/26/13, 08/27/13 and 08/28/13. A sample of 21 residents was selected from a census of 90. The sample included 21 current residents and one supplemental resident.<br><br>The survey was conducted by:<br><br>[redacted] MSW<br>[redacted], RN, MN<br>[redacted] MSW<br>[redacted] RN, MN<br>[redacted] RN, BSN<br><br>The survey team is from:<br><br>Department of Social and Health Services<br>Aging and Adult Services Administration<br>Residential Care Facilities Region 2, Unit F<br>20425 72nd Avenue South, Suite 400<br>Kent, Washington 98032-2388<br><br>Telephone: (253) 234-6000<br>Fax: (253) 395-5070<br><br>Mike Ambesse 09/10/13<br>Residential Care Services Date | F 000 | **Disclaimer Clause**<br>**Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of federal and state law.**<br><br>RECEIVED<br>SEP 20 2013<br>DSHS/ADSA/RCS Region 4 | 10/4/13 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Debi [illegible] | Executive Director | 9/20/13 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 176 SS=E | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review it was determined that the facility failed to ensure residents were assessed for safety of medications at bedside, including self-administration, storage, and monitoring for four (#s 55, 64, 52 & 117) of six residents observed with medications at bedside. This failure placed residents at risk of adverse effects from medication interactions, overdose and exacerbation of medical conditions.<br><br>Findings include:<br><br>FACILITY POLICY<br>According to the facility's 01/06 Self-Administration of Medication policy, "If a resident desires to self-administer medications, the Self-Medication Evaluation is completed. This evaluation is completed before the resident is allowed to self-administer.... If it is determined the resident may self-administer medications, the nurse: a. Obtains a physician order for self-administration for the specific medication(s), b. Initiates the Self-Medication Administration Care Plan, c. Determines whether medications will be stored at nursing station or resident's room, d. Initiates the Self-Medication Administration Record, if medications are stored at bedside...". | F 176 | **F-176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE**<br><br>**Cited Residents**<br>Resident #52 was assessed for self medication of multi dose inhaler when she goes out of the facility. Order was obtained from the physician and the MAR was updated.<br><br>Resident #55 was assessed, but refuses to secure medications in a locked box/drawer. Self-medication administration was dc'd.<br><br>Resident #64 does not want to participate in a self medication program. Medications were removed from the resident's room, physician orders were obtained and medications will be administered by the licensed nurse as ordered.<br><br>Resident #117 had current self medication assessment and care plan in chart. MAR reviewed and updated. Self med MAR initiated for the resident to sign when resident takes the medication. | ID463 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 176 | Continued From page 2<br><br>RESIDENT #55<br>On 08/22/13 at 1:38 p.m. Resident #55 was observed to have saline nasal spray at her bedside. In an interview at that time, Resident #55 said she used the nasal spray on an as needed (PRN) basis, "probably twice a day, every four hours, when I think about it." Resident #55 said she did not notify the nursing staff when she used the nasal spray.<br><br>Review of the resident's record revealed a 08/05/13 Physician's Order (PO) for saline nasal spray, two sprays to nostrils three times a day PRN. The order indicated, "May have it in bedside, dry nose." The August Medication Administration Record (MAR) listed the order as PRN and had no documented use.<br><br>The [redacted]/13 Admission Nursing Evaluation, Section IX Self-Administration of Medication, indicated the resident did not desire to self administer medications. If the response had been yes, the instructions indicated "If candidate for self-administration, request order for self-medication program and initiate self medication administration initial Care Plan (CP)." The resident's record did not contain a self-administration of medication assessment, PO for self administration, or a CP.<br><br>RESIDENT #64<br>During initial rounds on 08/21/13 at 8:33 a.m., Resident #64 was observed to have medications at his bedside including a bottle of [redacted] cold and flu relief liquid, a bottle of Aleve pain reliever, and a box of multi-symptom day/night cold medicine pills. In an interview at that time, Resident #64 said he used the [redacted] "one to two | F 176 | **Other Residents**<br>Upon admission, quarterly and as condition improves, resident will be asked if they desire to administer their own medications and the resident will be assessed.<br><br>**Education/Systems Review**<br>Nursing staff will be re-educated on the self medication program. All staff will be re-educated on reporting to licensed nurses if medications are found in resident rooms.<br><br>**Monitoring**<br>Periodic room audits for medications will be conducted by licensed nurses and managers to ensure continued compliance. Results of the audits will be forwarded to the CQI committee monthly times 3 months to review for further educational opportunities.<br><br>**Responsibility**<br>The Director of Nursing will be responsible for the ongoing compliance.<br><br>10/4/13 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 176 | Continued From page 3 | F 176 | | |

times a month, when my throat gets clogged up at night", the cold pills "only when I have a cold... I haven't for awhile", and the Aleve pills "whenever I need it."

Review of the resident's record revealed there were not POs for any of the above medications, or that the resident could have medications at the bedside, or self-administer medications.

The 09/15/12 Nursing Admission Evaluation indicated the resident did not desire to self medicate. The record contained no self-medication evaluation and no self administration CP.

In an interview on 08/27/13 at 11:38 a.m. Staff B indicated at a minimum POs for the medications were expected.

RESIDENT #52
On 08/22/13 at 8:46 a.m. Resident #52 was observed with [redacted] Meter Dose Inhaler (MDI) at the bedside. In an interview at that time Resident #52 said "I only use this when I go outside", "Like when I go out for walks, or go to my daughter's I use it." Resident #52 added, "In fact I have to turn it back into my nurse, I used it yesterday" and indicated the nurse had given her the MDI "to take with me yesterday."

Review of the resident's record revealed a 07/15/13 PO for [redacted] two puffs, every four to six hours PRN for shortness of breath. There was no PO indicating the resident could have the medication at the bedside, on her person, or could self-administer the medication. Review of the August MAR revealed the [redacted] was listed, but not documented as used. According to the

10/4/13

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 176 | Continued From page 4<br>12/07/12 Admission Nursing Evaluation the resident did not desire to self-administer medications. The record did not contain a self-medication evaluation or CP.<br><br>RESIDENT #117<br>Review of Resident #117's record revealed POs for Fluticasone nasal spray every 12 hours, [redacted] three times a day and saline nasal spray PRN. All three POs included "resident may keep at bedside", dated 07/23/13. There was no indication in the POs if the resident was to self administer the medications. The August MAR had all three medications listed and staff signed off each dose as if they administered it. There was no indication the resident self administered any of the medications.<br><br>A 07/27/13 CP identified the resident "Needs to have meds at bedside to be able to self administer meds as per POs specify; Res self administers bedside meds on a daily/prn basis per res request and per scheduled MD orders". Identified goals were that the resident would "administer bedside meds per self following POs daily" and "safely store bedside meds according to POs daily". Interventions included "Educate res on administration of meds (... secure location for storage), monitor res self administration and document on MARs, monitor administration times to verify MD orders as followed."<br><br>Observation on 08/27/13 at 9:41 a.m. revealed a [redacted] inhaler and A[redacted] at the resident's bedside unsecured. The resident's record did not contain POs for either of these medications.<br><br>In an interview on 08/27/13 at 11:20 a.m., Staff D stated there should be a PO for the medications | F 176 | | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 176 | Continued From page 5 | F 176 | | |

observed at the resident's bedside and they should be secured. Staff D also stated staff do not watch the resident administer the medications. She explained the resident reported when she took the medications and staff documented in the MAR. She stated the MAR should clearly indicate the resident self-administered certain medications, and acknowledged it appeared staff signed as if they administered it.

In an interview on 08/27/13 at 11:38 a.m. Staff B, DNS said "currently we don't have anyone on a self medication program." Staff B indicated if a resident had medications at their bedside they had to have a physician's order, a lock box for the medications and an assessment to ensure safe administration.

In an interview on 08/28/13 at 8:05 a.m., Staff F stated staff reviewed all resident rooms. They determined two residents (#s 55 and 52) wanted to continue to self-administer medications, so assessments were done and care plans completed. He stated the other residents who were observed with medications at their bedsides did not want, or were unable to self administer medications and so the medications at their bedsides were removed. He stated residents who self administer should keep the medications secured in a locked area in their rooms. When asked what the process was to ensure residents with medications at their bedside were assessed, he stated any staff member who saw a medication should notify the nurse who would then initiate the self medication policy. He acknowledged that had not consistently been done, based on the multiple residents identified with medications at bedside.

10/4/13

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 176 | Continued From page 6 | F 176 | | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review it was determined that the facility failed to provide an ongoing program of activities for one (#36) of three residents reviewed for activities of the 15 residents who were observed for activities in the Stage 1 sample. This failure placed the resident at risk for social isolation, boredom and a diminished quality of life.<br><br>Findings include:<br><br>RESIDENT #36<br>According to the 08/05/13 Minimum Data Set assessment, Resident #36 had adequate hearing but severely impaired vision. He was assessed with severely impaired memory and decision making abilities. He was totally dependent on staff for all of his care, including mobility.<br><br>During Stage 1 of the survey, on 08/21 and 08/22/13, the resident was not observed to participate in any activity. On 08/21/13 the resident was observed being fed lunch. Staff were not noted to speak to him, other than an occasional "here" or "open". On 08/22/13 at 1:34 | F 248 | **F-248 ACTITIVITES MEET INTERESTS/NEEDS OF EACH RES**<br><br>**Cited Residents**<br>Resident #36 has been discharged from the facility.<br><br>**Other Residents**<br>Other residents who are on a one-to- one activity program or whose preference is in-room activities were reassessed and/or interviewed for appropriate meaningful activities. Their care plans were revised to reflect their current needs and goals.<br><br>**Education/Systems Review**<br>Activity staff were re- educated on assessment and care planning to provide for an ongoing program of activities to meet the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>**Monitoring**<br>Management staff will conduct random weekly interviews and observations of the activity program to validate ongoing appropriateness and acceptance of the program. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 7<br>p.m., he was observed in his room, sitting in his wheelchair. No television or music was on, nor was any other stimulation present. A radio was not visible in his room, although a television was present.<br><br>The Initial Activity Evaluation, dated 03/26/13, identified the resident enjoyed movies, music, tv "for background noise", sensory stim (anything soft), outdoors, dogs, and stuffed animals. The 07/11/13 quarterly note indicated a hired caregiver was present during waking (day) hours. The resident's favorite activities were again identified as "background noise, tv, music, etc. Stuffed animals".<br><br>Review of the Activity Participation Record for July 2013 revealed on 20 of the 31 days, watching TV/movies was indicated and on 19 days a visitor was indicated. Three "sensory" activities were noted for the month. On 11 days in July, no activity participation of any kind was noted. In contrast, August's activity participation record indicated on four of 27 days a visitor was present, and on 13 of 27 days the resident watched TV or movies. Five additional activities were identified for the month of August including three sensory groups, a one on one and one "social" group.<br><br>The Preference for Customary Routine and Activities care plan, dated 07/11/13, identified the resident with an "Alteration in activity pursuit patterns (related to) physical disability, cognitive impairment, impaired mobility, impaired communication, sensory problems". The identified goals were resident "will attend/observe 2 recreational group activities each week; resident will respond to caregiver interaction". | F 248 | Results of the interviews and observations will be forwarded to the CQI committee monthly times 3 months to review for further improvement opportunities.<br><br>**Responsibility**<br>The Activity Director and Executive Director will be responsible for the ongoing compliance. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 8<br>Approaches included "assist with transport to/from activities as needed; encourage involvement in activities of interest (entertainment, pet visits, groups to be amongst others); escort to activities where sensory stim (background) sounds are present (related to a history) of such activity involvement; res has stuffed animals and vibrating toy in room for stim (these offer solace and stim); weather permitting take res outside for stroll".<br><br>A 07/22/13 Care Conference note indicated "Caregivers keep him entertained when awake."<br><br>On 08/23/13 at 2:23 p.m. the resident was observed in bed with the television on. A private caregiver was at his side. Observation on 08/26/13 at 10:24 a.m. revealed Resident #36 in bed. No tv or music was on. No caregiver was present. At 12:42 p.m., the resident was in the dining room for lunch. At 2:11 p.m., he was observed in bed with no tv, music or other audible stimulation. Similar observations were made on 08/27/13 at 9:26 a.m., 9:44 a.m., 10:44 a.m. and 11:45 a.m. when the resident was in his room with no tv, music or other activity. On 08/28/13 at 9:13 a.m. and 11:05 a.m., #36 was in bed. A stuffed animal had been placed at his side, but there was no tv or music on. A paid caregiver was not observed on 08/26, 27 or 28/13 .<br><br>In an interview on 08/27/13 at 11:20 a.m., Staff D stated facility staff should not rely on the paid, outside caregivers to provide the resident's care. She stated the caregivers used to be present daily, but they had "tapered off". She stated certified nursing assistants should turn on the TV or music, and give the resident something soft to hold for tactile stimulation. When asked how the | F 248 | | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 9<br>staff knew what type of music, tv or movies the resident enjoyed, Staff D stated those details should be included in the activity care plan and on the CNA care guide. Upon review, she acknowledged there were no details as to what the resident enjoyed in the care plans.<br><br>In an interview on 08/28/13 at 11:20 a.m., Staff E, Activity Director, stated the resident's paid caregiver historically took care of the resident's activities needs. She stated she had noticed the caregiver had not been present as often in August, however she unable to show a change in the resident's plan of care since the caregiver's visits had decreased. She stated the resident enjoyed "background noise". She explained any staff, not just the activity staff, should turn on the TV or music when the resident was placed in his room. She acknowledged she had not provided staff with information, either on the care plans or verbally, as to what type of programs or music he enjoyed. She explained the resident attended the sensory group twice a week, prior to lunch, but was unable to state any other group activities he had attended in the past few months. She stated she took a radio into the resident's room on 08/27/13 as she noticed he did not have one.<br><br>Once the facility identified the resident's situation changed, i.e. the frequency of the paid caregiver decreased, they failed to design a program to meet his activity needs. | F 248 | | 10443 |
| F 363 SS=E | 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED<br><br>Menus must meet the nutritional needs of residents in accordance with the recommended | F 363 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 363 | Continued From page 10<br>dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review it was determined that the facility failed to ensure pre-planned menus for resident meals were followed and residents were served the proper portions of certain foods. Failure to follow the menus placed all residents receiving meals prepared by the dietary department at risk for weight loss and/ or poor nutritional intake.<br><br>Findings include:<br><br>RESIDENT #131<br>During lunch observation on 08/21/13, Resident #131's tray card indicated the resident was to receive four ounces of apple juice, which the resident was not served. In an interview on 08/28/13 at 7:41 a.m. Staff G said Resident #131 "should have gotten" apple juice as indicated on the tray card.<br><br>RESIDENT #s 28 and 58<br>During lunch observation on 08/21/13 at 12:33 p.m., Resident #28 and #58 both said they did not want the meals they had been served. Staff removed both residents' plates and served them each the alternative, a grilled cheese sandwich, without any side items. According to the menu, the residents should have received additional items including soup and/or salad. In an interview on 08/28/13 at 7:41 a.m., Staff G said staff were not supposed to remove the whole meal and | F 363 | **F-363 MENUS MEET RESIDENT NEEDS/PREP IN ADVANCE/FOLLOWED**<br><br>**Cited Residents/Other residents**<br>Resident #131 was served 4 oz of apple juice when omission was noted. Resident #8's tray card was updated to include strawberry allergy, instead of dislike, per resident request. Dietary staff were immediately re-educated on tray accuracy, food allergens, puree recipes and portion control.<br><br>**Education /Systems Review**<br>Dietary staff were re-educated on following recipes for pureed foods and the correct scoop size, the use of thickener, products not to be served with milk allergy and portion size. Large portion policy posted by cook area for reference.<br><br>**Monitoring**<br>Tray line audits will be done 3 times per week for 1 month to ensure pre-planned menus for resident meals are followed and residents are served the proper portions of certain foods. Results of the audits will be | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 363 | Continued From page 11<br>residents should not be served only a sandwich.<br><br>Observation of the lunch meal on 08/26/13 at 12:45 p.m., revealed Resident #58 was served strawberry shortcake. His tray card indicated he did not like strawberries. The resident stated he was allergic to strawberries and expected his tray card would be followed.<br><br>In an interview on 08/26/13 at 9:58 a.m., Staff M stated dietary staff were expected to serve meals in accordance with what was planned, but also with respect for what resident's requested and their preferences.<br><br>LUNCH SERVICE<br>Observation of staff preparing the lunch meal on 08/23/13 revealed the puree cupcake was prepared with water and not milk. In addition, staff freely poured thickener into the cupcake puree, although the recipe did not call for it.<br><br>According to the Diet Spreadsheet for lunch on 08/23/13, staff should use a #10 scoop for residents who received puree or dysphagia cupcake. Staff were observed to use a #6 scoop for all residents who received that consistency of cupcake.<br><br>At 10:51 a.m., Staff L stated the kitchen ran out of cream of chicken soup, as was called for in the chicken and rice casserole, and so they used cream of mushroom. She also stated the recipe for the cupcakes directed "should be prepared with milk" and the thickener should be measured, not poured freely. She also stated while the recipe for the pureed casserole did not call for thickener, thickener was used. | F 363 | forwarded to the CQI committee times 3 months for further educational opportunities.<br><br>**Responsibility**<br>The Dietary Manager and Executive Director will be responsible for the ongoing compliance. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 363 | Continued From page 12<br>PORTION SIZES<br>According to the facility's Large and Small Portions policy, dated 08/11, residents who required large portions should be served one and one half portions of the entree and starch and double the portion of the bread/margarine. Residents who required a small portion should receive a half portion of everything, except the beverage.<br><br>During observation of the lunch tray service on 08/23/13, Resident #s 154 and 96 had orders for small portions, but were served regular portions. Resident #143's tray card directed he receive large portions, however he was served regular portions. Resident #106 received a large portion of the entree, but not the extra bread or starch as directed. Resident #s 36 and 89 were also served incorrect portion sizes. Resident #58 was not served the extra starch for the alternate menu despite an order for large portions. At 11:55 a.m., Staff G incorrectly informed dietary staff residents who required large portions should receive double portions of every item. Staff then proceeded to serve four residents double portion sizes, despite the policy that indicated one and a half portions were required.<br><br>Staff L acknowledged some residents received twice the portion size called for, while others received inaccurate portions of certain food items. She also stated when residents received larger portion sizes of the casserole, staff should have increased the amount of cheese used as a topping, but they had failed to do so.<br><br>Resident #105 had a milk allergy identified on the tray card, but was served the casserole, despite the use of a cream soup that had milk as an | F 363 | | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 363 | Continued From page 13<br>ingredient.<br><br>In an interview on 08/23/13 at 2:04 p.m., Staff G acknowledged staff failed to serve meals as directed by resident's orders and the menus. She stated training would be implemented immediately. | F 363 | | |
| F 364 SS=E | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure residents received food that was served at appropriate temperatures and consistency to maintain food quality and palatability. Seven (#s 2, 127, 52, 39, 22, 58, & 21) of the 18 residents interviewed during Stage 1 voiced concerns about the temperature, taste, or look of the food served. In addition, observations of melted ice cream and vegetables served with excess water were made. These failures placed all residents at risk for discontentment with their meals, compromised nutritional status, and possible weight loss.<br><br>Findings include:<br><br>During interviews in Stage 1, residents expressed a variety of concerns related to the food served. | F 364 | **F-364 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP**<br><br>**Cited Residents/Other residents**<br>Resident #39 and #39 were served fresh plates of lasagna and zucchini without the excess water. Ice chest coolers were purchased to keep ice cream on ice until ice cream is placed on meal trays. Cooks will strain excess water from vegetables prior to placing on plate with other food items.<br><br>**Education/Systems Review**<br>Staff were re-educated on food presentation skills, food temperatures, keeping hot food hot and cold food cold when served. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 364 | Continued From page 14<br>For example, on 08/21/13 at 11:27 a.m., Resident #2 stated much of the food was "tasteless" and the vegetables were "overcooked". On 08/21/13 at 2:14 p.m., Resident #127 stated the food had "no seasoning". On 08/22/13 at 8:28 a.m., Resident #52 stated food often had "no flavoring". On 08/22/13 at 10:16 a.m., Resident #39 stated hot food was often cold and cold food was room temperature when served. She stated ice cream was almost melted into milk by the time it was served.<br><br>RESIDENT #39<br>During observation of the lunch meal in the Main Dining Room on 08/21/13 at 12:28 p.m., Resident #39 was served lasagna and zucchini. The plate had standing water from the zucchini that had saturated the lasagna. The resident was observed to send the tray back and was served another plate, without the excess water.<br><br>In an interview on 08/22/13 at 10:15 a.m. Resident #39 said "The other day I had lasagna and zucchini and the plate was filled with water, they took the plate back and they said it was because of the zucchini but, I don't want my lasagna floating in water."<br><br>Similar findings were noted for resident #31 who on 08/21/13 at 12:48 p.m. was served lasagna and zucchini in a plate filled with fluid.<br><br>Observation of the lunch meal in the main dining room on 08/22/13 revealed staff served the dessert, ice cream, at the same time they served the meal to each resident. Resident #4 refused her meal but accepted the ice cream. When opened, it was melted. Resident #22 was also observed to have melted ice cream. | F 364 | **Monitoring**<br>Tray line audits will be done 3 times per week for 1 month to ensure foods are served at the proper temperatures and excess liquids are not present on plates with other food items. Results of the audits will be forwarded to the CQI committee times 3 months for further educational opportunities.<br><br>**Responsibility**<br>The Dietary Services Manager will be responsible for the ongoing compliance | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 364 | Continued From page 15<br><br>Observation of the lunch meal on 08/22/13 at 12:25 p.m. in the 200 dining room revealed seven residents, all of who had ice cream that was moderately melted. One resident was observed to place ice cubes in his ice cream, while another was observed to attempt to eat the ice cream, however the ice cream dripped off the spoon.<br><br>During observation of hall tray lunch service on 08/22/13, Resident #67 stated the ice cream and jello were frequently melted by the time they were served. Resident #92 similarly stated, "the ice cream was served today... melted around the sides, soupy".<br><br>TEST TRAY<br>On 08/23/13, a test tray was requested and at 1:54 p.m., after the last resident was served, temperatures and consistency were assessed. The broccoli had little flavor and was mushy. The mixed vegetables for the alternate meal were noted to be served with excess water on the plate.<br><br>In an interview at 2:04 p.m., Staff G stated the mixed vegetables should have been strained prior to serving. | F 364 | | 10/4/13 |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general | F 425 | **F-425 PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH**<br><br>**Cited Residents**<br>Resident # 187 has discharged from the facility.<br><br>Resident #105 diagnosis was clarified for medication use. Order for blood pressure was clarified with the physician. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 425 | Continued From page 16<br>supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review it was determined that the facility failed to ensure Physician's Orders were clarified, medications were administered as ordered and/or staff rotated injection sites for one (#117) of one residents reviewed for dialysis services and two (#s 187 and 105) of five residents reviewed for unnecessary medications of the 21 residents who were included in the Stage 2 review. These failures placed residents at risk for untreated medical conditions and medication errors.<br><br>Findings include:<br><br>RESIDENT #117<br>Review of Resident #117's record revealed a physician's order (PO), dated 06/01/13, that directed staff to administer the anti-hypertensive medication [redacted] twice a day. The order further indicated this medication should be held | F 425 | Resident #117 physician's order was clarified and MAR updated to reflect current dialysis days.<br><br>**Other Residents** Resident physician orders were clarified to ensure medications are administered as ordered and to ensure residents are not receiving unnecessary medications.<br><br>**Education/Systems Review**<br>Licensed nurses have been re-educated on clarifying physician orders.<br><br>**Monitoring**<br>Clinical staff will audit new physician orders during scheduled clinical meetings to validate complete and correct orders. Resident Care Managers will audit during monthly recap of orders to validate continued compliance. Results of the audits will be forwarded to the CQI committee monthly times 3 months to review for further educational opportunities.<br><br>**Responsibility**<br>The Director of Nursing will be responsible for the ongoing compliance. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 425 | Continued From page 17<br>"on dialysis days". Further record review revealed the resident attended dialysis on Tuesdays, Thursdays and Saturdays.<br><br>Review of the July and August Medication Administration Records (MAR) revealed staff did not consistently hold the medication when directed. The following dates were all dates the resident attended dialysis and therefore the Metoprolol should have been held. Staff documented the administration of the dose on the morning of 07/02 and 07/13, and the evening of 07/16, 23 and 30/13. Staff also noted administration of the medication on the evening of 08/06, 13 and 17/13. Further, staff documented the administration of both doses on 08/02/13, despite the resident attending an extra day of dialysis on that date.<br><br>Staff further documented the medication was held on the evening of 07/07 and 08/13 and the morning of 08/07/13, days the resident did not attend dialysis, however there was no indication of why the doses were not administered according to the PO. In addition, staff failed to document either the administration, or withholding, of the evening dose, on 07/01, 03 or 06/13.<br><br>In an interview on 08/26/13 at 1:45 p.m., Staff D stated it did not appear staff consistently followed the PO, as they failed to document holding the medication when indicated.<br><br>In addition, a 06/01/13 PO for [redacted] noted the medication would be administered by the dialysis center on Mondays, Wednesdays and Fridays. As the resident went to dialysis on Tuesday, Thursday and Saturday, the order should have | F 425 | | 10463 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 425 | Continued From page 18<br>been clarified to accurately reflect the administration of the medication. In an interview on 08/27/13 at 11:27 a.m., Staff D acknowledged the PO should have been corrected.<br><br>RESIDENT #187<br>Review of Resident #187's record revealed an order for [redacted] to be injected once a day between 07/22 and 08/05/13. Site documentation in the MAR revealed staff failed to rotate the injection site on 07/23, 07/24, 25 and 07/26/13.<br><br>According to the Nursing 2013 Drug Handbook located at the nurse's station, nursing considerations for the administration of [redacted] included direction to alternate "doses between left and right anterolateral and posterolateral abdominal walls."<br><br>In an interview with on 08/27/13 at 11:30 a.m., Staff D stated staff should alternate the injection sites for [redacted]<br><br>RESIDENT #105<br>Resident #105 had a 05/02/13 PO for [redacted] The PO did not identify a diagnosis for which the medication was administered. According to the Nursing 2013 Drug handbook, [redacted] can be used to treat a variety of diagnoses, including seizures, nerve pain and [redacted] disorder. In an interview on 08/27/13 at 9:51 a.m., Staff H stated staff were expected to clarify the diagnosis for which a medication was administered with the physician, to ensure adequate monitoring and indicators for its use. He acknowledged the [redacted] PO did not have an associated diagnosis.<br><br>In addition, a PO, dated 05/21/13, revealed staff | F 425 | | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 425 | Continued From page 19<br>should administer [redacted] daily, but hold the dose if the resident had a systolic blood pressure of less than 105. Review of the MAR revealed staff failed to consistently record the resident's blood pressure prior to administration of the medication in May, June and July, 2013.<br><br>In an interview on 08/27/13 at 9:51 a.m., Staff H acknowledged staff failed to consistently record the resident's blood pressure in conjunction with the administration of the medication. He stated staff were expected to follow the PO. | F 425 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. | F 431 | **F-431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS**<br><br>**Cited Residents**<br>Resident #101, #190 and #141 have been discharged from the facility.<br><br>Residents #189, #196, #63, #64 and #107: All open and undated vials, insulin pens, multi dose inhalers, eye drops and liquid medications were discarded and reordered from the pharmacy. Improperly labeled medication was removed from the medication cart and discarded.<br><br>Resident #81, #63 and #64 had unsecured medications removed from their rooms and stored appropriately. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 20<br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review it was determined that the facility failed to label, date and discard medications as indicated, on two of four medication carts and one of two medication rooms. This placed residents at risk to receive medications that were expired. Additionally, staff failed to ensure adequate medication storage for six (#s 81, 63, 117, 64, 55 & 52) of six residents observed with medications or treatments at bedside. This placed residents at risk for accidental ingestion of medication for which they were not intended.<br><br>Findings include:<br><br>Refer to CFR 483.10(n), F-176, Self Administration of Medication<br><br>UNDATED/EXPIRED MEDICATIONS<br>Observation of the East Medication Cart on 08/21/13 at 8:55 a.m. revealed a vial of [redacted] insulin which was dated as opened on 07/15/13, but on which no resident name was marked. In an interview at that time, Staff J stated, "I am not sure who that is for."A vial of [redacted] for | F 431 | Residents #52 and #55 were assessed for self medication administration with appropriate medication storage.<br><br>Resident #117 had current self medication assessment/care plan i in place and clarification was obtained from the physician related to the orders. Resident secures medication in locked drawer.<br><br>**Other Residents**<br>Medication storage areas were checked for open and undated vials, insulin pens, multi dose inhalers, eye drops and liquid medications. Any medications out of compliance were discarded and re-ordered from the pharmacy.<br><br>**Education/Systems Review**<br>Licensed nurses were re-educated on labeling, dating and discarding expired medications.<br><br>**Monitoring**<br>The SDC will perform periodic audits of medication storage areas to ensure compliance. Results of the audits will be forwarded to the CQI committee monthly times 3 months to review for further educational opportunities. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 21<br>Resident #101 was opened but not dated. Resident #196 had a vial of [redacted] insulin and [redacted] insulin, both of which were opened but not dated; Resident #190 had a vial of [redacted] insulin opened and not dated; Resident #141 had an insulin pen, opened and not dated. Resident #189 had [redacted] opened and not dated. A bottle of liquid potassium chloride and liquid [redacted] were opened however the pharmacy date sticker was not filled out and there was no other date identified on either bottle. According to Staff J, "if there is a date to be filled out for open, we should do so."<br><br>A vial of [redacted] was not dated. According to Staff D, "that shouldn't be there" (in the cart). She indicated the [redacted] should be refrigerated.<br><br>Observation of the SouthWest Medication Cart on 08/21/13 at 9:15 a.m. revealed a bottle of [redacted] eye drops and two bottles of [redacted] for Resident #63, all which were opened and not dated. In addition, a bottle of [redacted] was dated as opened on 06/04/13. [redacted] for Resident #64 was opened and not dated. Staff K acknowledged the above observations and stated all of the above medications should have been dated when opened to ensure they were discarded when expired. In addition, the pharmacy policy for [redacted] indicated it should be discarded six weeks after opening.<br><br>Observation of the SouthEast Medication Cart on 08/21/13 at 8:33 a.m. revealed a vial of insulin for Resident #107 dated as opened 07/08/13. According to Staff I, the insulin was no longer being used, however "nobody noticed" and it had not been removed from the cart. In an interview | F 431 | **Responsibility**<br>The Director of Nursing will be responsible for the ongoing compliance. | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 22<br>on 08/26/13 at 10:23 a.m., Staff B stated the insulin should have been removed from the cart. In addition, 26 loose pills were observed on the bottom of the cart drawer. Staff I stated they were due to "accidental popping". Staff B stated, on 08/26/13 at 10:23 a.m., nurses should clean out the loose pills when they observed them.<br><br>UNLABELED MEDICATIONS<br>Observation on 08/23/13 at 8:50 a.m. of the SE medication cart revealed a bottle of opticlear artificial tear eye drops. The outside of the box had a room number marked, however there was no resident name. Staff I, RN, stated the resident currently in the bed marked on the box did not have a physician's order (PO) for the eye drops. Staff I discarded the medication as it was "confusing" and staff were unable to determine for whom the drops were intended without a resident's name.<br><br>In an interview on 08/23/13 at 9:50 a.m., Staff I further explained if a medication was unmarked staff "should discard the medication because we don't know who it belongs to." She also stated as soon as a medication was opened, it should be dated.<br><br>UNSECURED MEDICATIONS<br>Resident #81 was observed, on 08/22/13, with a container of [redacted]powder, unsecured at her bedside. Review of the resident's record revealed no PO for use of the [redacted]or for it to be kept at the bedside. In an interview on 08/27/13 at 11:38 a.m., Staff B stated [redacted]was over the counter, so she did not necessarily think it needed to be secured. However, review of the powder revealed it was medicated with an antifungal agent. | F 431 | | 10/4/13 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505344 | A. BUILDING _____ B. WING _____ | 08/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CANTERBURY HOUSE | 502 29TH STREET SOUTHEAST AUBURN, WA 98002 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 23<br><br>Observation on 08/22/13 revealed a bottle of flucontizone nasal spray at the bedside of Resident #63. Record review revealed a PO for the nasal spray to be administered daily. There were no orders to keep the medication at bedside.<br><br>Similar observations were made for Resident #s 117, 64, 55 & 52, all of whom had medications unsecured at their bedsides.<br><br>In an interview on 08/27/13 at 11:38 a.m. Staff B, DNS, said medications kept in a resident's room must be secured in a lockbox, in addition to having a physician's order and an assessment to assure it was safe to do so. | F 431 | | 10/4/13 |